

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for dates of service 03/19/01?
 - b. The request was received on 02/22/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/10/02
 - b. HCFA-1500s
 - c. EOBs
 - d. Reimbursement data (EOBs from other carriers)
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/30/02
 - b. HCFA-1500s
 - c. Audit summaries/EOB
 - d. Peer Review letter dated 12/08/01
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/18/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 04/19/02. The response from the insurance carrier was received in the Division on 05/02/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The provider has not properly been reimbursed for services associated with an epidural steroid injection.

2. Respondent: letter dated 04/30/02
“There does not appear to be CPT Codes for fluoroscopy based upon the type of machine used for this service. Provider has not presented evidence, other than the original and maintenance cost of its machine, to show that under the Medical Fee Guideline, certain machines are to be billed under 76000 and other machines are to be billed under some other CPT Code.”

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only dates of service eligible for review are 03/19/01.
2. The carrier’s EOBs have the denials, “M – REDUCED TO FAIR AND REASONABLE” and “D – REIMBURSEMENT FOR UNILATERAL OR BILATERAL PROCEDURES IS BEING WITHHELD AS THE MAXIMUM NUMBER OF OCCURENCES FOR A SINGLE DATE OF SERVICE OR MAXIMUM LIFETIME FOR THE CLAIM HAS BEEN EXCEEDED.”

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
03/19/01	76499-27-22	\$300.00	\$105.60	M M	DOP DOP	Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d), Rule 133.304(i)(1-4); MFG, GI (III), CPT & modifier descriptors	Commission Rule 133.304 (i)(1-4) requires the carrier to explain its methodology in determining fair and reasonable. The carrier has submitted a response that contains its methodology. The carrier basis its reimbursement on the MAR of CPT code 76000-27, which is \$88.00 plus 20%. The MFG, GI (III)(A) states, "(DOP) in the ... (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." The provider has submitted EOBs from other carriers to document fair and reasonable reimbursement and comply with the criteria of Sec. 413.011(d) of the Texas Labor Code. Regardless of the carrier's methodology, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. Recent SOAH decisions have placed minimal weight to EOBs for documenting fair and reasonable reimbursement. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code. Therefore, based on the documentation available for review, no additional reimbursement is recommended.
03/19/01	76499-27	\$300.00	\$0.00	D	DOP	Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d), Rule 133.304(i)(1-4); MFG, GI (III)(A), CPT & modifier descriptors	The MFG, General Instructions (III)(A) states, "(DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation..." On the date of service in dispute, the medical report does not contain sufficient documentation of the billed DOP procedure. Therefore, no reimbursement is recommended.
Totals		\$600.00	\$105.60				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 11th day of June, 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.